FGI RCOE Webinar Transcript – Rural Communities Response: Evidence-Based and Emerging Practices for Opioid Use Disorder May 5, 2022

[00:00:00] **Michelle Day:** [00:01:00] Good afternoon, everyone. And welcome to The Fletcher Group. Rural Center of Excellence's webinar series. Today's session is scheduled to run from 2:00 PM to 3:00 PM Eastern Standard Time. My name is Michelle Day and I'm your moderator for this session, along with Janice Fulkerson and Erica Walker. A couple of brief housekeeping items,

and then we'll begin. You entered today's session on mute and your video was off and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop-down feature to communicate with either the panelists only, or panelists and attendees. Please direct all questions regarding the webinar content to the Q and A section.

Be advised that this meeting is being recorded and will be available to you on our website once it has been transcribed. You can [00:02:00] access our website at www.Fletchergroup.org. Also at the conclusion of today's session, there will be a short survey regarding the webinar content. Your participation in that survey is greatly appreciated and

it will only take a few moments to complete. Today's presenter is Michele Herrmann, Program Manager for Emergency Department Implementation of MOUD and the Southern Tier of New York State for University of Rochester Medicine, Recovery Center of Excellence. She began working in outpatient addiction treatment at Strong Recovery at the University of Rochester Medical Center in 2009.

And in 2016, she became the Opioid Overdose Prevention Training Coordinator. In 2020 Michelle joined the Recovery Center of Excellence as the Community Outreach Coordinator. Michelle is currently working toward her Master's in Public Health at the University of Rochester. Michelle, the floor is yours.[00:03:00]

[00:03:02] **Michele Herrmann:** Hello everyone. It's a pleasure to be here today to discuss our center's work. And I want to give a special thank you to the folks at The Fletcher Group for inviting me to speak today.

My goals for today's webinar are to introduce UR Medicine's Recovery Center of Excellence. Discuss the adaptation process for rural communities and provide an overview of the evidence-based and emerging best practices the center is disseminating and implementing. I have no disclosures. We often get asked the question,

what does your Center of Excellence do? Well, we've been working diligently since the fall of 2019 to reduce morbidity and mortality related to substance use disorder with a particular focus on synthetic opioids. While our target service area includes 23 Appalachian county needs in Kentucky, [00:04:00] Ohio, New York, and West Virginia, that were hard hit by the opioid crisis,

anyone is welcome to benefit from our work. Today, all US states and territories have participated in our events or used our products along with 81 other countries. Our approaches to disseminate evidence-based practices that have been identified through research and carefully adapted to rural communities. Our programs are part of an ecosystem of recovery.

This ecosystem, which will be discussed in a few minutes, addresses a wide range of needs across the continuum or the community and the continuum of care. We have a program assistance center, which is available for support in planning and implementing any of the programs we will review today. Our contact information will be shared at the end of the webinar.

So, how do we adapt our evidence-based and emerging best [00:05:00] practices to rural communities? First, we identify the evidence which typically is researched in urban or suburban locations. We look at the scientific literature and then consult with our team of subject matter experts in the fields of rural health and substance use disorder.

Then we adapt these best practices in conjunction with those subject matter experts, to the demographic, cultural, economic, and infrastructure realities that are in rural communities. Then we need to get those adapted best practices out to those would benefit that we do this through relationship building with rural communities.

Um, we worked with stakeholders, our outreach team, our program assistance team, as well as our data collection and analytics. The Center develops products that support learning and [00:06:00] implementation of these adapted best practices and provides robust toolkits to assist organizations in the implementation process. Our Program Assistance,

also known as technical assistance, Center builds client relationships. And support the planning and program implementation for our clients. We also refer to the otherRCORP Rural Centers of Excellence on substance use disorder, The

Fletcher Group, today's host, and the University of Vermont Center on Rural addiction.

Then we evaluate how we're doing. We look at our established baseline measurements. We report on a regular basis and we analyze our programs impact in the communities that we're serving. And we followed the cycle through all of the products, impress practices that we've disseminated to date. Next. I just want to provide a snapshot of the work.

The center has focused on each of these best [00:07:00] practices fit into one or more of five pillars or priority areas. As you can see, each practice makes up the ecosystem of recovery. Let's take a closer look at these practices, starting with the impact of COVID-19. Very early on, we realized that we needed to address how COVID-19 is impacting access to treatment. Two areas that were greatly impacted by the pandemic were group therapy and access to medications for opioid use disorder or MOUD. Especially when it comes to opioid treatment programs.

We partnered with an outpatient substance use disorder and opioid treatment program called Strong Recovery here in Rochester, New York to develop workflows protocols and toolkits that other organizations could use to continue to provide access to much needed treatment options. [00:08:00] There was a need to suspend in-person group therapy in March, 2020.

And there was a need to find an alternative way to provide group therapy. Video conferencing group therapy was established to continue this treatment modality. The practice can be used beyond its needs during the pandemic and open up for more options to rural providers to provide group therapy services.

There are different formats for video conferencing group therapy. There is single point point where patients are gather in a group and the therapist connects, uh, via telemedicine, uh, from a different location. And this can be very beneficial for rural communities who may be experiencing clinical staff shortages.

The other option is a multi point format where patients and clinical staff joined from separate locations, uh, through the video platform. This allows for problems for social or [00:09:00] physical distancing based on the health needs for the pandemic, but it can also allow for increased access to patients in rural communities.

So this helps for things like if a patient has family needs such as childcare or even any kind of work responsibilities they may have. Another needed changed during COVID-19 was to adapt opioid treatment programs dispensing process. We, again, partnered with Strong Recovery on their practices to continue to dispense MOUD. This particularly impacted workflows for methadone dispensing. Social distancing tele-health services, expanded take-home medications and curbside dispensing allowed for Strong Recovery to keep the delivery of services safe for both patients and staff. And that curbside dispensing, um, what occur, uh, you know, patients would come in and park in designated parking spots in the [00:10:00] parking lot, and they would have a staff member come and meet them at their car, get their information, and then go back to the clinic and hand deliver that medication to the vehicle.

Um, on our learning page for our website, we have toolkits which include tip sheets, work flows such as the curbside dispensing, um, supply lists, uh, state and federal resources, uh, that treatment organizations can utilize.

Next, we also needed to figure out how can we reduce stigma around substance use disorder. Stigma is such a huge barrier to individuals accessing treatment. And so one way to do that is to bring people in contact with a person who's been stigmatized because of their substance use or opioid use disorder and educate individuals about evidence-based treatment

and recovery. So our team developed a community conversation [00:11:00] workshop on opioid use disorder. This center facilitated interactive workshop, utilizes art, some prompt, the discussion around defining stigma and its impact on those affected by opioid use disorder. Charmaine Wheatley. Who's the artist. Um, you can see the, uh, the portrait here on the right.

Uh, she traveled to a rural community in Kentucky to meet with individuals and paint their portraits. She used their words as they discuss their experience with opioid use disorder and how they were stigmatized by their community, by providers and even their own loved ones. We use these portraits and the community conversations workshop, but we can also provide a toolkit for other communities to use and creating their own art campaign.

The workshop explores negative and positive beliefs around opioid use disorder and recovery. There's a discussion about ways to identify and overcome barriers and [00:12:00] challenges and addressing and reducing stigma. And participants

learn uh, about support resource says how to build relationships. They can say with them and use to reduce stigma in their clinic.

Surveys are distributed to participants before the workshop to engage perception of stigma from whether it be community members or providers or other ancillary staff, such as front-end personnel. Uh, the surveys are then distributed again after the workshop to see if there was a change in perception amongst participants and for the

workshops that we've done to date. Uh, we have seen a pretty significant change in the perception, um, after the workshop was completed, um, in a, in a positive direction. So we're, we're, you know, reducing that, that stigma. Um, the workshop is about an hour to an hour and a half, um, could be upwards of two [00:13:00] hours.

Um, and it's also available as a train the trainer. So for individuals who are interested in becoming, um, a trainer. Um, please reach out to our program assistance center and we will connect you with a facilitator who will be able to, um, do the train the trainer course. So you can bring this training right to your community.

Another practice we've disseminated is the Rural Opioid and Direct Support Services or ROADS Program. And this is really seeking to remove the barriers for individuals with opioid use disorder, um, and increase their access to medications for opioid use disorder in their rural community roads helps to alleviate the burden of long distance travel for individuals which can be costly and disruptive

to their work or family obligations. You [00:14:00] having to travel one to three hours in order to get to treatment, especially if somebody is receiving a treatment such as methadone medication, um, um, having to go in on a daily basis that becomes very costly and cumbersome and disruptive for that person's life.

Um, This model utilizes a central opioid treatment program, uh, which may be in an urban location and then auxiliary medical units, which are in the rural areas to actually dispense the medication for folks. Uh, the auxiliary sites use telemedicine to consult with the central opioid treatment program.

And they're able to facilitate patients access to other services at the clinic. Um, so we talked about the tele-health for group therapy. Patients would be able to go to that auxiliary medical unit to be able to engage in the group therapy. Um, they're also available for [00:15:00] individual and family counseling

um, in addition to that, um, ROADS programs are equipped with broadband access for patients to use, to be able to connect to other services. They may require.

Our next program addresses those impacted by incarceration. According to SAMHSA, overdose is the leading cause of death among formerly incarcerated individuals. So we partnered with the Transitions Clinic Network to adapt their program to rural communities. The Transitions Clinic Network's goal is really to improve access to care upon release.

And it connects the individual via a community health worker with lived experience before or after the release in order to help navigate their care post release. So partnering Transitions Clinic Network, um, these, uh, TCN programs they're often in [00:16:00] primary care practices, uh, typically federally qualified health centers.

Um, and they can address chronic health conditions, including opioid use disorder. Um, with these individuals, they also are able to provide Naloxone and medications for opiod use disorder as needed.

There are focus is not only on substance use disorder or opioid use disorder, but it also able to treat other medical conditions that these individuals need. The TCN programs focus on cultural and trauma informed care, which seeks to reduce stigma. Um, again, as I said, you know, stigma is that is a huge barrier to individuals accessing treatment.

So if they're able to get primary care treatment in a non-stigmatizing way, it has a much more, um, beneficial impact on their engagement. Uh, the community [00:17:00] health workers embedded into these practices and they can assess the formerly incarcerated individuals with care coordination for things like substance use disorder treatment, um, or transitional housing or other warm handoffs that an individual may need such as employment, uh, insurance, getting insurance and, uh, you know, parental rights questions for these individual.

On our learn page, we have a web series and, uh, have a toolkit with a fact sheet, um, planning and implementation information. There's tips on recruitment. Um, you know, there's a job description in there for the community health worker, um, as well as tips on the retention of the community health workers, which is so important.

Um, we also have workflows engagement plans. Um, there's regulatory guidance on there as well as a financial tool.[00:18:00]

Our next practice is around suicide prevention. We, you know, one thing that we saw very early on in the pandemic is, uh, an increase in, um, suicide rate. And we wanted to do something to address that. And so we partnered with SafeSide Prevention to adapt their already established evidence-based screening modules to address suicide risk and its intersection with opioid use disorder in rural communities, the modules include a video guided instruction and a demonstration of a systematic framework for suicide prevention.

They're designed to be done in a small group setting that allows for, you know, discussion and, um, some demonstration, uh, and role-playing um, and for those who are in the 23 county service region, uh, served by our center, the [00:19:00] subscription for the training is available at no cost. Um, for those outside the service area, they can, uh, access the training by subscription with SafeSide, for

um, for further questions, feel free to reach out to our program assistance center. Again, the contact information will be on the last slide.

Attention to how we respond to substance use is urgently needed. As we respond to the evolving overdose crisis. The over 30% rise in overdose stats in 2020 have been linked to synthetic opiates. Synthetic or excuse me, stimulants. And the use of substances in combination. The aim of this resource page is to provide communities including health and human services, providers, individuals with a substance use disorder, uh, their families and friends and [00:20:00] local leaders with a convenient evidence-based tool,

uh, that they can use and share and addressing the risks associated with poly substance use. One of the tools we've developed is called Facts for Life. And you can see a section of that tool here on the right. And it really discusses, um, you know, a multitude of factors that may increase, uh, overdose when it comes to poly substance use.

Um, it goes over the dangers of counterfeit pills, um, which are a major cause of overdose deaths. It reviews the dangers of fentanyl and its prevalence. Um, you know, we're seeing fence know more and more in the drug supplies on the street and, um, being, you know, pressed to these counterfeit pills, uh, it reviews, um, information about the dangers of mixing [00:21:00] drugs and using drugs alone.

Um, you can access this step, uh, this document, it's a downloadable PDF. Um, and there's also a 15 minute video. Um, on the dangers of polysubstance use on our learning page.

So let's jump in and talk a little bit more about the ecosystem of recovery. So we need to start that off by talking about our current state. What does, what does it look like right now? So for an individual to access care. Uh, to treat their substance use disorder. It looks a lot like this, this illustration here, especially in our rural communities. Um, when an individual is seeking treatment, they run into a lot of closed doors.

Um, you know, and, and one of those doors that's always open though, is the emergency department. Um, but stigma is prevalent across the board, whether it be in the primary care office [00:22:00] or the treatment program or the emergency department. So what happens to an individual when they go to the emergency department? They're assessed, treated for their medical means not always the behavioral health needs provided information on treatment options, you know, maybe a piece of paper or a brochure for the patient to initiate.

And then they're discharged. This process does not offer the important non-stigmatizing support a person who uses drugs needs, to needs in order to start on their recovery journey. So it begs the question, how can we change the system of care for individuals seeking recovery? We need to establish a framework.

So the framework that rural communities can use around the ecosystem of recovery provides a [00:23:00] community-wide support using evidence-based and emerging best practices around opioid use disorder treatment. And it begins by establishing partnerships across the community. So we have individuals, these champions or these early adopters and

those community partners are able to provide patients with access to treatment. You know, whether it be in their, um, their home, in their primary care office, in the emergency department and in the treatment centers, it ends with a

community wide support for patients in recovery and care management, integrated into primary care practices.

The system is designed to increase screening. Provide timely access to treatment, which is very, very important, um, and also help an individual sustain long-term recovery. [00:24:00] And we do this with engagement of primary care providers in this system of care. So how would a, a rural community start this process? First, we need to build a system that's geared toward the local needs.

What, what are, what are folks seeing at home. And then partnering with other organizations. And this could be organizations, you know, in, in their town or in their village or in their county or other, uh, partners outside the immediate area. So is there a, you know, a larger, um, health system that we can connect with? And then applying those best practices over a period of time?

Um, you know, this could be one to two years a time. It's, it's not something that can happen overnight. And there are six key components to implementing this framework. First, we need to identify the crisis, right? What is [00:25:00] happening locally? What are we seeing? And then we need to create the conditions for change.

So how can we create an environment where we can garner support within our community? And then we did community needs assessments. You know, what are those who are living here think the health priorities are? And then establish a system implementation plan. How can we take what we learned in steps one through three, and then set up a system for change.

We also need to identify barriers. You know, where are we running into challenges? Well, you know, what, what are some biggest, big barriers that people are encountering as we're either looking to get them engaged in treatment, or as we're assessing, uh, setting up this system implementation. And then we modify the plan as needed as we do in any kind of, you know, optimization [00:26:00] period, you know, what's working, what isn't, what can we do to fix it?

So let's make this change. And this is where we hope to be. Um, and our future state for the ecosystem of recovery. You know, we still have our emergency department, our treatment program and our primary care offices.

And we start those partnerships and that's really the kind of that start in creating the conditions for change. So let's first talk about how we can bridge the gap between a treatment program and primary care. We establish a bridge program to connect rural communities, to medications for opioid use disorder, which may not be available in their local primary care practices.

And this bridge program connects providers in rural communities via telemedicine to [00:27:00] providers outside of the immediate area, to serve as a two to three-year bridge that supports patients in their recovery and the continuation of medications for opioid use disorder until the rural primary care provider has become trained and waivered.

And part of that is also that they have the competence and come and feel comfortable in order to continue to prescribe this medication. Um, you know, so if they get wavered and they don't use it, um, you know, that's not helping anybody, but if they get waivered, you know, whether they submit their notice of intent to treat up to 30 patients, or if they complete the required training

um, and so they can treat over 30 patients, you know what we want to be able to get them to, to gain that confidence, to continue the prescribing of the medication. This bridge program also establishes a tele-health link. Um, [00:28:00] and that really closes a known gap, especially in our rural communities, from, you know, between the providers, whether it's the primary care or the treatment program or the, the emergency department.

And our center is currently developing a video-based education modules for primary care providers to integrate substance use disorder treatment into their practices. And this will allow these rural PCPs to treat all medical means of patients that they already see, including substance use disorder. Next let's jump to the emergency department,

where we place a behavioral health assessment officer or a BHAO, uh, BHAO is a licensed behavioral health provider working in a rural emergency department who evaluates, manages the care and engages, identified patients who have screened at risk for behavioral health concerns. [00:29:00] The BHAO allows for rural emergency departments to increase their screening of patients

for both substance use disorder and mental health concerns, and if needed and see consultation via that tele-health link with a partnering psychiatrist at a

central clinic location. They are also able to provide Naloxone to patients, um, right from the emergency department, as needed. And one of the hospitals that we partnered with, uh, in the, um, Northern Appalachian region here in New York state, um, one of the providers, uh, gave us some great feedback on, um, our BHAO and they said, our BHAO is a great resource for staff providing guidance and deescalation techniques.

And facilitating therapeutics to ensure we provide [00:30:00] appropriate compassionate care for psychiatric patients. And that compassionate care really stems from that stigma reduction work that we do. Included in the services and rural emergency department um, is the provision of medication for opioid use disorder.

Um, when implementing this, uh, here in the Southern tier region of New York, we engaged chief medical officers, um, pharmacists from the hospital, um, nursing staff providers and the BHAO. So all these folks came around the table and we started this discussion and this collaboration really allowed for a smooth implementation

for the emergency department to start this program. When the patients are screened by the BHAO in this process and if they meet a criteria for opioid use disorder, um, and are in withdrawal, according to [00:31:00] the COWS Scale, um, they have the option to start the induction process of buprenorphine right in the emergency department.

They're monitored throughout the process. And once the patient is no longer in withdrawal. Again, this is a kind of a re-evaluation, um, every hour or so, uh, utilizing the COWS Scale or Clinical Opioid Withdrawal Scale on the patient can be discharged. Now, this isn't kind of in that, from that current state, um, you know, where we just, you know, start them on the medication and tell them to reach out to folks.

It's we then partner with a peer from a treatment program. And the BHAO engages that peer, um, really right after the screening process. And the peer can start that facilitation with the BHAO for a warm handoff. So the patient has somebody with them guiding them along this process so they can continue their [00:32:00] medication.

They can start treatment based on their needs, whether it's inpatient, outpatient, um, you know, whatever it happens, um, that they need. And really those peers

have play a pivotal role in early engagement with patients. Um, they can be dispatched to the, uh, rural emergency department and they really offer unique perspectives through their lived experience.

Um, they engage with a patient really from bedside. Um, and, uh, they can continue to work with the patient, uh, throughout their treatment journey, um, from the emergency department and throughout their program, um, at the treatment program.

Next we want to bring in the local community. You know, this is where those stigma workshops we discussed earlier coming in. We want to educate the community about what substance use disorder is and what it is [00:33:00] not. Um, we want the community at large to understand that addiction is not a moral failing or a lack of willpower.

Um, we want them to know that substance use disorder is a chronic disease that when managed people do recover from. And that recovery can have many pathways. Including medication. And so we want to educate and dispel any stigma around medications for opioid use disorder as well. We need to increase the messaging that MOUD is not trading one drug for another, but it's part of a person's treatment.

Um, just as it would be for any other chronic condition. We also need to provide the suicide prevention training and a community-wide access to Naloxone. And it really helps to create and foster a safe [00:34:00] environment for patients to recover in.

And we want to move our focus over to the primary care office, where we put a behavioral health care manager. And this behavioral health care manager, BHCM as a licensed behavioral health worker who is embedded right in the primary care office. And as part of the treatment team, BHCM's are part of a, kind of a collaborative care model of treatment.

Um, that's really most feasible and sustainable in rural communities. Um, they're able to provide brief treatment and connection to other services a patient may need, you know, whether it is, um, you know, housing services or connection to, um, you know, eye doctors, um, or you know, what ever other needs that the individual may need.

They're able to answer [00:35:00] mental health and substance use disorder questions. And able to provide follow-up care. Uh, they support medication management from the practice office and use evidence-based practices in their counseling.

And you see this dotted line from primary care back to treatment. This represents that returned to use or relapse is part of the process of recovery. Um, management of a chronic disease is not a linear process. You know, if a person has a return to use and the BHCM, um, can refer the patient back to the treatment program and re-engage that peer, then the patient can return back to the primary care practice when they're back in that medication maintenance phase of their treatment.

I spoke earlier about the five [00:36:00] pillars to address priority areas in substance use disorder treatment. This is just a snapshot of what we used while building the ecosystem of recovery here in the Appalachian region of New York. Um, so let's dive in a little bit deeper and talk about these priority areas.

Um, I've reviewed. And, um, you know, how this kind of all came together and, uh, creating the ecosystem and the practices that are in the yellow boxes are examples of practices that can be implemented to support each pillar. But the community has the ability to implement each one of these practices for whatever will work best for their unique needs.

So if you know, one of these practices under the pillars might not work best in your community, you know, you can use another approach. So first the first pillar we want to look at is [00:37:00] that we seek to save lives. Uh, in general, we recommend starting here, but it's not always possible. So this is where your Naloxone distribution comes in.

This is where this, um, suicide prevention training comes in. Um, that engagement from the emergency department and providing MOUD right from the emergency department and an as part of that polysubstance use awareness campaign that we, that we've put out. Um, then we want to engage our community through a shared understanding and leadership.

Uh, we want to work with those early adopters that I had mentioned before in creating these conditions for change. Um, and this is where we can identify those champions in our community. You know, how can we establish this, this

early adopter, this champion network? Um, this is where we can engage the community through the community discussions on stigma.

Um, this is where we can also start that conversation with [00:38:00] medical staff and the primary care offices around stigma and around the stigma associated with medications for opioid use disorder. Um, this is where we can involve the behavioral health assessment officer. And we want to make sure that not only are we educating the community around stigma, but that we also educate ourselves

about our words because our words matter. So we need to be able to educate folks on using non-stigmatizing language. Um, again, the polysubstance use, um, awareness campaign kind of folds into that engagement of community, really educating across the spectrum. And the third pillar is to expand access to treatment.

We really want to meet people where they are having to drive a long period of time to. Uh, you know, get treatment, uh, is, is a huge barrier to folks. So how can we bring treatment to their community? [00:39:00] And we, we need to look at our community, you know, where are folks showing up? Is it the emergency department?

Is it their primary care office? Are they going to the library? Are individuals, you know, looking at their school and going to their school? And then utilize those evidence-based practices to bring the treatment right to them. And so, you know, in our case, um, we did the ED-based MOUD. So we, we were able to bring the treatment rate to their, uh, you know, local, um, rural hospital.

And then starting that bridge program. Um, so for the bridge program that we set up in, one of the counties, um, in, uh, in a Southern region actually had a room, like a tele-health room that individuals were able to go. They booked the appointment in the room and they were able to have that tele health bridge, um, service to one of our partnering providers here in the Rochester area.[00:40:00]

You could also utilize ROADS in this situation. So again, bringing those ancillary medical units rate into the rural community and connecting to that central OTP. And then also working with the transitions clinic network programs, um, to engage and expand treatment for individuals who are recently released from incarceration.

And then the fourth pillar really highlights this increased need for screening to prevent substance use disorder. Um, you know, we need to be able to screen for substance use disorder and mental health conditions across the board, whether it is in the emergency department or in primary care. Um, and you know, utilizing that behavioral health care manager in the primary care practice, you know, utilizing that suicide prevention training, utilizing the behavioral health assessment officer.

And engaging the patient [00:41:00] right from that screening process to then maybe being able to start the medication right from the emergency department. And then finally the fifth pillar is supporting recovery. If we're able to do one through four, but we cannot support an individuals recovery. None of it. None of the other stuff matters.

So we want to be able to support individuals in recovery. How can we create a safe environment for individuals to recover? We need to create that non-stigmatizing, uh, community around them, you know, through those community discussions. Um, we need to engage our, the community recovery supports, you know, whether it's the grassroots folks or maybe it's 12 step. Um, perhaps there's recovery fitness programs in the area. Um, and also focus on recovery oriented, social events and holidays.

Where perhaps drugs or alcohol may be present [00:42:00] normally, but in this case they're able to celebrate, um, without drugs or alcohol there. And also recovery housing. You know, this is that The Fletcher Group, uh, uh, you know, um, focus is that recovery housing, creating a safe environment for people to recover in. But we always, we want to be mindful to invest in our care managers in our, and in our peers.

They're really the keys to engagement in this process. But we also want to engage and invest in our community and, you know, the stigma being the biggest barrier to accessing care. If we can get rid of that, we have such a great opportunity to help people in recovery.

I want to wrap up by sharing an exciting, uh, upcoming event that the recovery center of excellence is hosting. Our center is hosting [00:43:00] the national world substance use disorder, health equity, and stigma summit on May 18th through the 20th this year. Uh, we're doing this in partnership with the other RCORP Centers of Excellence.

So The Fletcher Group and University of Vermont Center on Rural Addiction. This is a hybrid event, which will be in-person here in Rochester, New York at the Eastman School of Music. And we'll also be hosted virtually. If you're interested in learning about actionable strategies to help rural communities address stigma and promote health equity for individuals with substance use disorder or opioid use disorder.

Um, if you want to share brag a little bit about the successes that you have implemented, some of these evidence-based strategies with your peers, um, if you want to connect with other communities to establish a learning network, you know, sharing what works and what didn't work amongst different communities can really help open the door for folks.[00:44:00]

Um, or if you just want to learn more, come and join us, this month, 12 days away, um, the event is free. It's open to the public. Um, we have an incredible lineup of speakers. Um, we will be offering continuing education credits, uh, at no cost to participants, whether in-person or virtually. Um, and for more information, go to takingaction.Vfairs.com.

Um, there, you can see our speaker lineup. Um, our agenda is actually going to be posted on Monday. So take a peek at that and please register. Um, we would love to have you join us. As promised I was going to share our contact information. Uh, we'd love to be able to connect with you. If you have an interest in learning about any of the work that we went over today.

Um, or if you have any questions or ideas about work, we may be able to do in the future. [00:45:00] Um, you can follow us on Twitter and LinkedIn. Uh, we post updates and share various events of the work, um, and the products that we're working on. Um, so please, uh, connect with us. We'd love to hear from you. Um, This wraps up my presentation.

Uh, so thank you all for joining. Um, I believe we're going to open up for questions.

[00:45:23] **Janice Fulkerson:** Thank you, Michelle. We are going to open it up for questions. We've got quite a few for you. So the first one that came in, um, was related to peer services. Um, our certified peer services integrated into the services that you've talked about today.

And are they a nonclinical or more clinical? Maybe you can expand on.

[00:45:46] **Michele Herrmann:** Absolutely. Um, so the peer services that we utilize in the ecosystem of recovery here in New York, our certified recovery peer advocates. So this is a certification through New York state, the peer [00:46:00] role as a nonclinical role, but they are still part of the treatment team.

And so they do participate in treatment planning, um, and, and help with that, that connection to other services. Um, the, the peers, um, for the partnering, um, clinics that we, that we work in, um, are able to, like I said before, come right to the emergency room to, um, you know, increase that engagement and they really follow that patient along.

So the patient has, you know, someone who understands what they're going through, walk with them throughout the whole process.

[00:46:38] **Janice Fulkerson:** Terrific. Thank you. Um, and if anybody wants to learn more about peer services and how some of the social model, uh, recovery supports fit into a medical model, uh, you can reach out to any of our Centers of Excellence.

At the University of Rochester, Vermont or Fletcher Group. [00:47:00] Okay. Um, another question, Michelle, for you, uh, you mentioned on slide 14, the community needs assessment. Do you see organizations doing their own needs assessment or partnering with groups that may be like governmental agency, non-profits or hospitals to complete a more community focused, more broad based needs assessment.

Can you speak to the needs assessments?

[00:47:27] **Michele Herrmann:** I, I've actually seen it at several different ways. Um, so we've seen, uh, some community needs assessments that are distributed by the local health system. Um, we've seen some that it's a collaborative approach. Um, maybe the, you know, the hospital, main hospital in the area kind of takes the lead, but then they engage, um, you know, uh, stakeholders from primary care from law enforcement.

Um, I've seen some where they include recovery oriented organizations. Um, and then I've [00:48:00] seen other ones where they kind of blend different community needs assessments together to kind of get like an aggregate needs assessment for perhaps a broader area. So, um, it, it really just depends on what

that community requires and then really finding that champion to, to, to get it off the ground.

[00:48:24] **Janice Fulkerson:** Great. Thank you for that. Um, another follow up question. Um, if an organization wants to incur it, bring, uh, awareness and stigma education to their community in a more broad way. And they haven't seen anything in their community yet in a rural community. Where would someone start? What would be your advice on where to start?

[00:48:50] **Michele Herrmann:** Where to start? Honestly. One of the best places, uh, where we started for say our, um, um, our, our campaign. [00:49:00] Cause we actually, um, engaged with coalitions. So, uh, drunk coalitions in certain areas, and those coalitions are made up of, uh, uh, you know, groups of individuals from really across the community. Um, for instance, uh, one, uh, we worked with, um, a, uh, recovery art program.

And they had a connection to a drug court. And so we were able to, um, engage with folks who are participating in drug court and do their portraits. And then we displayed the portraits right in the drug court to address stigma on that front. Um, Uh, another way, uh, we actually worked and we started the conversation right from the, um, the leadership at the hospital and how we can, uh, start with.

Get that conversation going around stigma from the emergency department perspective. Um, we've also worked with, [00:50:00] uh, you know, chief medical officers who oversee primary care practices and started the conversation there. So it really depended on, you know, where folks were seeing stigma most prevalent and talking with the individuals who are being stigmatized.

Um, and their families and see, where were you, you know, where did you experience this? And then starting the conversation off and engaging those folks.

[00:50:29] **Janice Fulkerson:** Thank you.

Um, I also have had experience with other organizations who have started to put their local United Way, their local, federally qualified health care clinics, and some others who maybe have a shared vision and just starting a conversation by asking questions, you know, could be a small group. And then it leads to a movement.

Um, question Michelle. Uh, we have, uh, two more questions and then I'll look to see if we have any more coming in. [00:51:00] Okay. Um, can you speak more to your train the trainer program that you mentioned? What is it and who can access it?

[00:51:09] **Michele Herrmann:** Absolutely. So the train, the trainer course, um, for the community discussion, um, we've partnered with a facilitator.

Her name is Tedra Cobb, and she offers this train, the trainer course and goes through, um, the discussion topics for that community discussions workshop. Um, with individuals it's typically a smaller group setting, maybe three to six people. It takes about three hours to do, and it can be done in person or virtually.

It's really up to the community and you know, what works best for, for the folks who are interested. And she educates folks on how to, you go through the presentation and facilitate that conversation, um, with the community members. Um, as I said, it's, it's accessible to anybody. It's free of [00:52:00] charge for anybody who is interested in the train the trainer.

Um, if you are interested in that you can either email the, um, the program assistance center, which is on your screen right now. Or you can go ahead and send me an email. Um, I believe. Janice, you're going to share my email.

[00:52:17] **Janice Fulkerson:** Um, yes. I put your email in the chat, along with the contact information for the University of Rochester.

Um, uh RCOE um, and all of the information that's here on this slide has been put into the chat so people can grab that if they'd like. Um, also another reminder is that this presentation um, along with the materials will be available on The Fletcher Group website next week, uh, for attendees to grab. Um, and the summit information, both to register for the University of Rochester summit and The Fletcher Group summit that is following there's the next month in Memphis, June eight and nine.

[00:53:00] That information is in the chat is. So Michelle, one final question for you. Uh, do most emergency rooms in rural communities, have a BHAO and if not, how could someone support getting one.

[00:53:16] **Michele Herrmann:** Absolutely. Um, I was lucky enough to actually, uh, work on this implementation project from the get-go. Um, and so not every emergency room emergency department has a BHAO.

Um, we were able to, um, utilize, uh, the grant funding, um, from HRSA for the RCORP to hire the um, hire and train these BHAO to be, um, embedded in the emergency department. If you are interested in how to get a BHAO, um, recruitment, job descriptions, um, financial modelings around BHAOs, um, as well as any kind of reimbursement opportunities

um, we actually, uh, [00:54:00] have on our learn page. Um, we did a webinar, um, on, around the BHAO. Um, you can jump to our learning page or again, um, send me an email. Email the Recovery Center of Excellence and we would be happy to work with your organization and really dive in deep and talk about that process. Um, we actually, uh, created, um, kind of a combination of, um, uh, evidence-based screening tool that, uh, it's seven questions that emergency departments can roll out.

Um, so they're able to really capture folks and really kind of gauge, um, you know, who might be utilizing the services of a BHAO. Um, and then, uh, we have also a training, um, for BHAOs available for those who are interested.

[00:54:50] **Janice Fulkerson:** Thank you, Michelle. I think the beauty of the three Centers of Excellence that we have at University of Vermont, University of [00:55:00] Rochester and the team here at Fletcher Group is the collaboration across the three organizations. If there's something one of us can do really well, we will do it. If there's something else our colleagues can do better, we will make a referral. And I think one of the things that we're all very good at is developing those toolkits and even more, helping people with the implementation because there some science to the implementation of the information that's provided in a tool kit.

So thank you, Michelle. Thanks for joining us today. Thanks to everybody who is on the webinar that joined us today as well. Um, all three RCOE information is available to you by contacting any one of us. So thanks for joining us today and look for more information in your email about next month's webinar.

Thanks Michelle.

[00:55:54] **Michele Herrmann:** Thank you all. Thank [00:56:00] you.

[00:56:01] **Michelle Day:** This concludes our webinar session. Thank you so much for

joining us today. Also, please tune in on the first Thursday of each month from 2:00 PM to 3:00 PM Eastern Standard Time where we will be hosting subject matter experts from across the nation to bring you valuable tools and resources for rural recovery house operators and SUD professionals. If you would like information on technical assistance, you can go to our website. Again, www.fletchergroup.org, which I have also copied in the chat, and submit a technical assistance request.

Lastly, please take a moment to respond to the survey questions once they become available on your screen. Your feedback is very important and greatly appreciated. Thank you and have a blessed day.